
MEDI-CAL ELIGIBILITY PROCEDURES MANUAL

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17A-INTRODUCTION

1. BACKGROUND

State law provides limited Medi-Cal coverage to persons who need special types of life sustaining medical treatment. Such individuals are obligated to pay a percentage of the treatment costs for services not covered by other insurance or other government programs, based on their net worth.

These special provisions are limited to persons in need of kidney dialysis or parenteral hyperalimentation treatment (also known as total parenteral nutrition or TPN). TPN provides total nutrient replacement through a catheter positioned in the chest for persons who, for whatever reason, are unable to eat and digest food.

2. DEFINITION OF DIALYSIS AND RELATED SERVICES

Dialysis and related services are defined in Title 22, California Code of Regulations, Section 51157, and are as follows:

A. Renal Dialysis

"Renal dialysis" means removal by artificial means of waste products normally excreted by the kidneys. Such removal may be accomplished by the use of an artificial kidney or peritoneal dialysis on a continuing basis.

Note: Renal dialysis includes full-care, self-care, or home-care dialysis.

B. Related Services

"Related Services" means hospital inpatient and physician's services related to the treatment of renal failure, stabilization of renal failure, treatment of complications of dialysis, and dialysis related laboratory tests, medical supplies, and drugs.

3. DEFINITIONS OF TYPES OF DIALYSIS

A. Full Care Dialysis

Full-care dialysis is provided in a dialysis clinic or a hospital outpatient clinic. Treatment is fully managed by staff, the patient takes no part in managing his or her own care.

B. Self-Care Dialysis

Self-care dialysis takes place in a "self-care dialysis unit" of a dialysis clinic or hospital outpatient clinic. The patient manages his or her own treatment with less staff supervision required.

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C. Home Dialysis

Home dialysis takes place in the home. The patient has a home dialysis unit and dialyzes at home. Usually a dialysis clinic or outpatient hospital clinic will supervise the patient's home care and will provide needed supportive services, including the services of qualified home dialysis aides on a selective basis.

4. BENEFICIARY PORTION OF SPECIAL TREATMENT PROGRAM COSTS

Special Treatment Program beneficiaries must pay a percentage of the cost of each dialysis or TPN service. The percentage is based on their annual net worth—a combination of property and annual gross income (some property is exempt). The "percentage obligation" that these beneficiaries must pay is indicated on the Point of Service (POS) device when the provider verifies patient eligibility through the Automated Eligibility Verification System (AEVS). The provider uses that percentage figure to calculate what the beneficiary owes on each service. Patients who are Special Treatment Program—Supplement beneficiaries are also entitled to use that amount towards meeting the regular Medi-Cal share of cost.

5. OTHER HEALTH COVERAGE AND BILLING PROCESS

If the patient has Medicare, private health insurance, or any other non-Medi-Cal coverage, that coverage must be billed first for the cost of a TPN or dialysis service. Counties are required to enter appropriate Other Health Coverage (OHC) codes on Medi-Cal Eligibility Data System (MEDS) and obtain a completed Health Insurance Questionnaire form (DHS 6155) as needed for this population when health insurance is available or has changed. The patient's percentage obligation applies to the balance remaining after payment by such other coverage. For example, if Medicare covers \$80 of a \$100 charge, the patient's percentage obligation will be applied only to the remaining \$20. The provider subtracts what the beneficiary owes from the \$20 and bills Medi-Cal for the rest.

6. MEDS PROCESS

All new Special Treatment Program records must be added to MEDS by the county using either online or batch transactions. The Medi-Cal Special Treatment Program—Percentage Obligation Computation, Form MC 176D, (Exhibit A) will continue to be used to determine the percentage obligation for applicants of Special Treatment Programs. It must be completed at the time of a new application, restoration, reapplication, change in net worth affecting percentage obligation, and redetermination.

The MC 176D forms should not be forwarded to the Department of Health Services. Counties should retain the original MC 176D in the case folder.

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17B – ELIGIBILITY REQUIREMENTS AND PROCEDURES

1. SPECIAL TREATMENT PROGRAMS – "Only" Group

Persons who need dialysis, or total parental nutrition (TPN), and related services may be eligible for limited Medi-Cal Special Treatment Programs coverage if all of the following conditions are met in a month:

- o In need of dialysis, or TPN, and related services;
- o Not eligible for regular Medi-Cal because of excess property;
- o Not currently eligible for Medicare if under age 65 (applies only to Dialysis);
and
- o Meet standard Medi-Cal requirements for citizenship or legal immigration status, linkage, cooperation, and residency.
- o For TPN "Only": Medi-Cal linkage requirements are not necessary.

NOTE: Retroactive Medi-Cal benefits are not available for the "Only" group.

Reporting Responsibilities

All applicants and beneficiaries must report any change in status that could affect their dialysis or TPN program eligibility or their percentage obligation. These include, but are not limited to:

- o Loss of employment (may be able to qualify for full scope Medi-Cal disability if no longer working and engaging in substantial gainful activity);
- o Increase/decrease in earnings;
- o Change in marital status;
- o Change in other health coverage; and
- o Change in property.

NOTE: If a Medi-Cal Special Treatment Programs – Only beneficiary loses such program eligibility because he/she becomes eligible for regular Medi-Cal, eligibility must also be determined under Medi-Cal Special Treatment Programs–Supplement.

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2. SPECIAL TREATMENT PROGRAMS – "Supplement Group"

Persons who need dialysis, or TPN, and related services and who are eligible for regular Medi-Cal may also be eligible for limited Medi-Cal Special Treatment Programs coverage if all of the following conditions are met in a month:

- o In need of dialysis, or TPN, and related services;
- o Receiving either home dialysis or self-care dialysis;
- o Employed or self-employed, with gross monthly earnings which are greater than the individual Medi-Cal maintenance need for one person;
- o Otherwise eligible for Medi-Cal Medically Needy or Medically Indigent program with a share of cost; and
- o Meet standard Medi-Cal requirements for citizenship, legal immigration status, cooperation, property and residency.

All applicants and beneficiaries must report any changes in status that could affect their dialysis or TPN program eligibility or their percentage obligation. These include, but are not limited to:

- o Loss of employment;
- o Change in marital status;
- o Increase/decrease in earnings;
- o Change in other health coverage; and
- o Change in property.

NOTE: If a Medi-Cal Special Treatment Programs—Supplement beneficiary loses such program eligibility because of excess resources, eligibility must also be determined under Medi-Cal Special Treatment Programs—Only.

3. AID CODES

- o All eligibles for dialysis services should be reported to MEDS as aid code 71.
- o All eligibles for TPN services should be reported to MEDS as aid code 73.

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4. INFORMATION ON MEDI-CAL DIALYSIS AND TPN SPECIAL TREATMENT PROGRAMS

A. Advantages

This program provides medical cost relief for dialysis, TPN, and related services. Under the regular Medi-Cal program, the beneficiaries must pay or obligate all their surplus income toward meeting their share of cost for medical care. Under this program, they need to pay only a percentage of the cost for dialysis or TPN services after any other health coverage payment is subtracted from the cost of those services.

B. Dialysis--Only Program Services

Dialysis "Only" covers related hospital and physician services associated with the treatment of renal failure, stabilization of renal failure, treatment of complications of dialysis and dialysis-related laboratory tests, medical supplies, and drugs.

C. Dialysis--Supplement Program Services

Dialysis Supplement covers a wide range of dialysis services except routine full-care dialysis. Routine full-care dialysis is not a Dialysis Supplement benefit. This exclusion does not preclude provision of full care dialysis treatment in the case of a physician-certified medical emergency.

D. TPN--Only Program Services

TPN--Only covers inpatient hospital care directly related to TPN, including home TPN training, home TPN, and related services and supplies.

E. TPN--Supplement Program Services

The TPN Supplement covers inpatient hospital care directly related to TPN, including home TPN training, home TPN, and related services and supplies.

F. How Dialysis and TPN Supplements Relate to Regular Medi-Cal Eligibility

Dialysis and TPN Supplements cover only the services described in Sections C and E above. If the beneficiaries or their families need other types of medical care, they must meet their regular Medi-Cal share of cost before they can receive regular Medi-Cal. The amount they pay for dialysis, TPN or related services as part of the Dialysis or TPN Supplement program will also be a credit against their regular Medi-Cal share of cost, just the same as any other medical bill they pay. Dialysis Supplement coverage ends when the beneficiaries meet their regular Medi-Cal share of cost. At that point, all medical services including dialysis or TPN, will be billed under the regular Medi-Cal aid code for the remainder of the month.

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5. DETERMINATION OF ANNUAL NET WORTH FOR MEDI-CAL SPECIAL TREATMENT PROGRAMS

The amount of the percentage obligation to be paid toward each dialysis, TPN or related service depends on the annual net worth of the beneficiaries and their spouse or the beneficiaries and their parents if they are under 18, unmarried, and living with their parents. Annual net worth is based on combined annual gross income plus property holdings.

The percentage obligation is computed as follows:

- o If the annual net worth is less than \$5,000, individuals pay nothing.
- o The percentage obligation for Dialysis or TPN- -Only is two percent per each \$5,000 of net worth.
- o The percentage obligation for Dialysis or TPN- -Supplement is one percent per each \$5,000 of net worth.

Persons in family units with a net worth of more than \$250,000 are not eligible for benefits under the Special Treatment Programs.

The following are not counted as part of the property holdings:

- 1) The first \$40,000 of the fair market value of the applicant's or beneficiary's home. The remaining market encumbrances, shall be included in annual net worth determination.
- 2) One motor vehicle used to meet the transportation needs of the individual or family.
- 3) Life or burial insurance purchased specifically for funeral, cremation, or interment expense, which is placed in an irrevocable trust or which has no loan or surrender value available to the recipient.
- 4) Wedding and engagement rings, heirlooms, clothing, household furnishings and equipment.
- 5) Equipment, inventory, licenses, and materials owned by the applicant or beneficiary which are necessary for employment, for self-support, or for an approved plan of rehabilitation or self-care necessary for employment.

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17C—MEDICARE ELIGIBILITY AND THE MEDI-CAL DIALYSIS SPECIAL TREATMENT PROGRAMS

I. IMPORTANCE OF MEDICARE FOR DIALYSIS ELIGIBLES

Counties must closely monitor the Medicare eligibility of dialysis cases for the following reasons:

- A. A Dialysis—Only beneficiary who is under 65 loses Dialysis—Only eligibility once Medicare eligibility is established.
- B. Although Dialysis—Supplement eligibility does not end when Medicare eligibility is established, Medicare takes over most of the dialysis costs from that point.
- C. Medicare eligibility does not affect eligibility for Medi-Cal Special Treatment Programs—Supplement.

II. MEDICARE ELIGIBILITY REQUIREMENTS FOR DIALYSIS PATIENTS

To be eligible for the Medicare Dialysis program:

- A. The individual must be fully or currently insured under Social Security or must be the spouse, dependent child, former spouse, widow, etc., of an insured individual. Fully insured individuals have 40 calendar quarters of covered employment under Social Security; currently insured individuals must have 6 out of the past 13 calendar quarters of covered employment under Social Security.
- B. The individual must be suffering from chronic kidney failure.
- C. The individual must apply with Social Security for Medicare benefits.

III. WAITING PERIOD FOR MEDICARE COVERAGE

There is a three-month waiting period between onset of chronic kidney failure and the beginning of Medicare coverage. However, patients who are eligible for Medicare Dialysis may have the coverage begin as soon as their application is completely processed by Social Security as follows:

- A. Individuals who enter self-care or home dialysis training at any time during the three-month waiting period will have the entire waiting period waived; their Medicare coverage begins with the first month of treatment for chronic kidney failure.
- B. Medicare coverage is retroactive, for up to 12 months before application, if the person met the coverage criteria in the past months. So a person whose Medicare application is not approved until the fourth month after kidney failure sets in, would have coverage start at the time of application, providing that the person met the eligibility criteria requirements for the Dialysis program.

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IV. MONITORING CHANGES IN MEDICARE ELIGIBILITY

A. Background Information

1. Medicare Application

Social Security district offices generally expedite the applications of persons in need of dialysis treatment. Staff usually are able to evaluate the information given and to inform the applicant whether it appears there will be eligibility for Medicare, either at the time of application or shortly thereafter. Under certain circumstances, however, a Medicare eligibility determination may become complex, and a timely evaluation is not possible.

In most cases, Social Security will inform applicants whether or not they are eligible for Medicare within three months of application. If there has been no response received by the end of the third month, the applicant must check with Social Security.

2. Calendar Quarters of Coverage

Upon request, Social Security will provide to individuals a statement of their quarters of covered employment called "Quarters of Coverage". Social Security reports may understate quarters of coverage by up to one year (four quarters) for currently employed persons. An estimate of how many quarters of coverage are required before an employed person, or covered dependent, will become eligible for Medicare can be made by subtracting the number of existing quarters of coverage from the number of required quarters.

For example, a person with 2 quarters of coverage may only have to work in a job covered under Social Security for one additional year (or 4 calendar quarters) to have the required 6 out of the last 13 calendar quarters of coverage to become eligible for Medicare. Similarly, a person with no quarters of coverage would have to work for 18 months to become eligible for Medicare.

B. CLIENT RESPONSIBILITIES

1. Applicants must apply for Medicare coverage within ten days of making application for a Special Treatment dialysis program, unless they provide a current Social Security statement of Medicare status. Failure to do so without good cause will result in denial of the application.
2. Special Treatment Dialysis program beneficiaries must provide the county with a copy of the Social Security statement of Medicare status, or any evidence of eligibility such as a card or letter, within ten days of receiving such evidence.
3. Beneficiaries shall cooperate with the county as requested if there has been no response to their Medicare application within three months of the application date.

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4. Beneficiaries who are determined to be currently not eligible for Medicare, but who are employed or are the spouse or dependent child of an employed person, shall request a statement of Quarters of Coverage from Social Security and shall provide this information to the county welfare department. (Social Security "Benefit Estimate Form".)
5. Beneficiaries are required to complete and return a Medi-Cal Status Report every calendar quarter. They will frequently use this form to tell the county for the first time of a change in Medicare status.

C. COUNTY RESPONSIBILITIES

1. The county shall review the facts it has received on the beneficiary's Medicare status at the time the first quarterly status report is sent. If the result of a Medicare application has not been reported by then, the county shall: (1) require the beneficiary to follow up with Social Security and report to the county or (2) inquire directly of Social Security regarding the beneficiary's Medicare status via the "Social Security-Public Assistance Agency Information Request and Report" (SSA 1610).
2. The county shall reevaluate eligibility when information on Medicare status is received. Medi-Cal Dialysis Only beneficiaries who are under 65 will be ineligible for program benefits once Medicare coverage begins.
3. The county shall report the Health Insurance Claim (HIC) number for all continuing Medi-Cal Special Treatment Program dialysis beneficiaries on the MC 176D when Medicare coverage is established.
4. The county shall set up a reevaluation "tickler" date based on the number of calendar quarters of coverage required for beneficiaries to become eligible for Medicare in the future. Eligibility shall be reevaluated in the month it appears the beneficiary will become eligible for Medicare.

IV. RETROACTIVE MEDICARE COVERAGE AND MEDI-CAL OVERPAYMENTS

As noted earlier, Medicare Dialysis coverage for a person may be retroactive. A Medi-Cal Special Treatment Program dialysis beneficiary may therefore be retroactively eligible for Medicare for the same period that Medi-Cal has already paid for dialysis treatment. As long as the beneficiary has met the Medicare application and verification requirements of the dialysis programs in a timely manner, such payments will not be considered overpayments by Medi-Cal. In addition, the Medi-Cal program is allowed to bill Medicare for its share of retroactive coverage.

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MEDI-CAL DIALYSIS SUPPLEMENT SPECIAL TREATMENT PROGRAM

CLIENT INFORMATION NOTICE

(County Stamp)

Notice Information Date: _____
Case No.: _____
Worker Name/No.: _____
Worker Telephone No.: _____
Name: _____

If you need kidney dialysis and qualify for the Medi-Cal Dialysis Supplement Special Treatment Program, that program could reduce your out-of-pocket dialysis costs. Here are key facts and rules about the program.

I. Dialysis Supplement Eligibility Requirements

You must meet all of the following conditions in a month:

- In need of dialysis.
- Eligible for regular Medi-Cal with a personal or family share of cost.
- Employed, or self-employed, with gross earnings which are greater than the individual Medi-Cal maintenance need for one person.
- Receiving either home dialysis or self-care clinic dialysis.

II. Information for Dialysis Supplement Program

A. Advantage of Dialysis Supplement Program

This program provides you medical cost relief for dialysis and related services. Under the regular Medi-Cal program, you must pay all your surplus income toward meeting your share of cost for medical care. Under this program, you need pay only a percentage of the cost for dialysis services after any other health coverage payment is subtracted from the cost of those services.

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B. Using Your Other Health Coverage

If you have Medicare, private health insurance, or any other non-Medi-Cal coverage, that coverage must be billed first for the cost of a dialysis service. Your percentage obligation applies to the balance remaining after payment by such other coverage. For example, if Medicare covers \$80 of a \$100 charge, your percentage obligation will be applied only to the remaining \$20. The provider subtracts what you owe from the \$20, and bills Medi-Cal for the rest.

C. What You Pay Toward the Cost of Your Dialysis Care

The amount you pay toward each dialysis service depends on the annual net worth of you and your spouse, or you and your parents if you are under 18. Annual net worth is annual income plus property holdings. The following are not counted as part of your property holdings:

The first \$40,000 of the fair market value of your home; one motor vehicle used to meet the transportation needs of you or your family; life or burial insurance purchased specifically for funeral, cremation, or interment expense, which is placed in an irrevocable trust or which has no loan or surrender value available to you; wedding and engagement rings, heirlooms, clothing, household furnishings and equipment; equipment, inventory, licenses, and materials owned by you which are necessary for employment, for self-support, or for an approved plan of rehabilitation or self-care necessary for employment.

If your annual net worth is less than \$5,000, you pay nothing. If it is \$5,000 or more, you pay one percent of the net cost of each dialysis service for each \$5,000 of annual net worth you have. For example, if your annual net worth is \$15,000, you pay three percent of the net costs of each dialysis service. The percent you pay is called your "percentage obligation."

D. How Your Dialysis Supplement Eligibility Fits into Your Regular Medi-Cal Eligibility

Dialysis Supplement covers dialysis and related services only. If you or your family need other types of medical care, you must meet your regular Medi-Cal share of cost before Medi-Cal will pay for covered services. The amount you pay for dialysis and related services as part of your Dialysis Supplement eligibility will be a credit against your share of cost, just the same as any other medical bill you pay. Dialysis Supplement coverage ends when you meet your regular Medi-Cal share of cost. At that point, all medical services including TPN Supplement will be billed under your

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regular Medi-Cal coverage for the remainder of the month.

E. What Happens if You Lose Regular Medi-Cal Eligibility

Eligibility for Dialysis Supplement depends on eligibility for the regular Medi-Cal program. If you lose eligibility for regular Medi-Cal for any reason, including accumulation of excess resources, you will no longer be eligible for Dialysis Supplement. In this case, the county welfare department will determine your eligibility under the Dialysis Only Program.

III. Services Covered by the Medi-Cal Dialysis Supplement Program

A. Dialysis Supplement Benefits

The Medi-Cal Dialysis Supplement program covers the full range of dialysis services except routine full-care dialysis. Routine full-care dialysis is not a Dialysis Supplement benefit. This exclusion does not preclude provision of full-care dialysis treatment in cases of a physician certified medical emergency. Dialysis Supplement coverage ends when you meet your regular Medi-Cal share of cost, since for the rest of the month you are entitled to free Medi-Cal services, including routine full-care dialysis.

B. Definition of Dialysis and Related Services

Dialysis and related services are defined in Title 22, California Code of Regulations, Section 51157 as follows:

- "(a) 'Renal dialysis' means removal by artificial means of waste products normally excreted by the kidneys. Such removal may be accomplished by the use of an artificial kidney or peritoneal dialysis on a continuing basis.*
- "(b) 'Related services' means hospital inpatient and physician's services related to the treatment of renal failure, stabilization of renal failure, treatment of complications of dialysis, and dialysis related laboratory tests, medical supplies, and drugs."

*(Note: "Renal dialysis" means full-care, self-care, or home-care dialysis.)

C. Definitions of Types of Dialysis

1. Full-care dialysis is provided in a dialysis clinic or a hospital outpatient

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clinic. Treatment is fully managed by staff, the patient takes no part in managing his or her own care.

2. Self-care dialysis takes place in a "self-care dialysis unit" of a dialysis clinic or hospital outpatient clinic. The patient manages his or her own treatment with less staff supervision required.
3. Home dialysis takes place in the home. The patient has a home dialysis unit and dialyses at home. Usually a dialysis clinic or outpatient hospital clinic will supervise the patient's home care and will provide needed supportive services, including the services of qualified home dialysis aides on a selective basis.

IV. Your Responsibilities

A. Medicare Application

1. You must apply for Medicare coverage within ten days of making application for this program unless you already have Medicare coverage or have a statement from Social Security showing you are currently not eligible for Medicare.
2. You must provide the county welfare department a copy of the Social Security Medicare status, or any evidence of eligibility such as a card or letter, within ten days of receipt.
3. If you are not currently eligible for Medicare, you must request a statement of quarters of coverage from Social Security (Social Security Benefit Estimate Form). You should determine, with the aid of a Social Security representative, how many more quarters of coverage you need to become eligible for Medicare. This information must be given to the county welfare department or your eligibility will have to be redetermined every quarter. It is your direct advantage to apply for Medicare as soon as you believe you are eligible. The cost you must pay is based on the balance left after Medicare or any other insurance has paid. Medicare coverage can reduce your cost up to 80 percent.

B. General Reporting Responsibilities

You must report any change in status that could affect your dialysis program eligibility or your percentage obligation. These include, but are not limited to:

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- Loss of employment.
- Change in marital status.
- Increase/decrease in earnings.
- Change in other health coverage.
- Change in property.

I have reviewed the above information with the county representative. I understand my responsibilities in regard to Medicare and general reporting requirements.

Applicant

Date

I have explained the Medi-Cal Dialysis Supplement requirements listed above to the applicant.

County Representative

Date

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MEDI-CAL TOTAL PARENTERAL NUTRITION (TPN) SUPPLEMENT SPECIAL TREATMENT PROGRAM

CLIENT INFORMATION NOTICE

(County Stamp)

Notice Information Date: _____

Case No.: _____

Worker Name/No.: _____

Worker Telephone No.: _____

Name: _____

If you require parenteral hyperalimentation treatment, also known as total parenteral nutrition (TPN), and qualify for the Medi-Cal TPN Supplement program, that program could reduce your out-of-pocket TPN costs. Here are key facts and rules about the program.

I. TPN Supplement Eligibility Requirements

You must be all of these things in a month:

- In need of TPN.
- Performing home TPN treatment.
- Eligible for regular Medi-Cal with a personal or family share of cost.
- Employed, or self-employed, with gross monthly earnings which are greater than the individual Medi-Cal maintenance need for one person.

II. Information for TPN Supplement Eligibles

A. Advantages of TPN Supplement Program

This program provides you medical cost relief for home TPN treatment. Under the regular Medi-Cal program, you must pay all your surplus income toward meeting your share of cost for medical care. Under this program, you need pay only a percentage of the cost for home TPN treatment after any other health coverage payment is subtracted from the cost of those services.

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B. Using Your Other Health Coverage

If you have Medicare, private health insurance, or any other non-Medi-Cal coverage, that coverage must be utilized or billed first for the cost of home TPN treatment. Your percentage obligation applies to the balance remaining after payment by such other coverage. For example, if Medicare covers \$80 of a \$100 charge, your percentage obligation will be applied only to the remaining \$20. The provider subtracts what you owe from the \$20 and bills Medi-Cal for the rest.

C. What You Pay Toward the Cost of Your Home TPN Treatment

The amount you pay toward your home TPN treatment depends on the annual net worth of you and your spouse, or you and your parents if you are under 18. Annual net worth is annual income plus property holdings. The following are not counted as part of your property holdings:

The first \$40,000 of the fair market value of your home; one motor vehicle used to meet the transportation needs of you or your family; life or burial insurance purchased specifically for funeral, cremation, or interment expense, which is placed in an irrevocable trust or which has no loan or surrender value available to you; wedding and engagement rings, heirlooms, clothing, household furnishings and equipment; and equipment, inventory, licenses, and materials owned by you which are necessary for employment, for self-support, or for an approved plan of rehabilitation or self-care necessary for employment.

If your annual net worth is less than \$5,000, you pay nothing. If it is \$5,000 or more, you pay one percent of the net cost of your home TPN treatment costs for each \$5,000 of annual net worth you have. For example, if your annual net worth is \$15,000, you pay three percent of the net costs of your home TPN treatment costs. The percent you pay is called your "percentage obligation".

D. How Your TPN Supplement Eligibility Fits into Your Regular Medi-Cal Eligibility

TPN Supplement covers home TPN supplies and related services only. If you or your family need other types of medical care, you must meet your regular Medi-Cal share of cost before Medi-Cal will pay for covered services. The amount you pay for home TPN supplies and related services as part of your TPN Supplement eligibility will also be a credit against your regular Medi-Cal share of cost, just the same as any other medical bill you pay. TPN Supplement coverage ends when you meet your regular Medi-Cal share of cost. At that point, all medical services including TPN Supplement will be billed under your regular Medi-Cal coverage for the remainder

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of the month.

E. What Happens if You Lose Regular Medi-Cal Eligibility

Eligibility for TPN Supplement depends on eligibility for the regular Medi-Cal program. If you lose eligibility for regular Medi-Cal for any reason, including accumulation of excess resources, you will no longer be eligible for TPN Supplement. In this case, the county welfare department will determine whether you are eligible under the TPN Only program.

III. Services Covered by the Medi-Cal TPN Supplement Special Treatment Program

A. TPN Supplement Benefits

The TPN Supplement Special Treatment Program covers only a limited range of outpatient benefits. You may use your TPN Supplement for approved nutrient solutions and related supplies, related laboratory services, and outpatient physician visits.

If you require treatment for an underlying condition, acute hospital care, or other forms of medical care, you must meet your regular Medi-Cal share of cost before Medi-Cal will pay for these services.

IV. Your Responsibilities

A. Medicare Application

You must apply for Medicare coverage after you apply for this program if you are receiving Social Security Title II Disability benefits.

You must provide the county welfare department with a copy of the Social Security Medicare status statement, or any evidence of eligibility such as a card or letter, within 60 days of your Medicare application. If Social Security does not provide you with a Medicare status statement within 60 days, you must provide a copy to the county welfare department as soon as you do receive it.

B. General Reporting Responsibilities

You must report any change in status that could affect your TPN Supplement Special Treatment Program eligibility or your percentage obligation. Such changes include, but are not limited to:

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- Loss of employment.
- Change in marital status.
- Increase/decrease in earnings.
- Change in other health coverage.
- Change in property.

I have reviewed the above information with the county representative. I understand my responsibilities in regard to Medicare and general reporting requirements.

Applicant

Date

I have explained the Medi-Cal TPN Supplement requirements listed above to the applicant.

County Representative

Date

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State of California—Health and Welfare Agency
Medi-Cal Program

Department of Health Services

MEDI-CAL SPECIAL TREATMENT PROGRAMS—PERCENTAGE OBLIGATION COMPUTATION

Co. Dist.	County Line
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PART I. IDENTIFICATION

A. Special Treatment Program Application				D. Date of Eligibility		F. Percentage Obligation	
Name (first, middle, last)				____/____/____ (Month) (Year)		____ %	
Address (number, street)				E. Redetermination Date		G. Program	
(city, state, ZIP code)				____/____/____ (Month) (Year)		<input type="checkbox"/> Dialysis <input type="checkbox"/> TPN <input type="checkbox"/> Supplement	
B. MNMI Medi-Cal Case Name:							
C. MNMI Medi-Cal ID Number				Medi-Cal Special Treatment Program ID Number			
Co.	Aid	7-digit Serial Number	FSU	Pers.	Co.	Aid	7-Digit Serial Number
				Birth Date		Sex	
				Month/Day/Year		Other Cov. Code	
						(1) SSN	
						(2) HIC or RR Number	

PART II. ELIGIBILITY REQUIREMENTS—SUMMARY

SPECIAL TREATMENT—ONLY, PROGRAM		SPECIAL TREATMENT—SUPPLEMENT, PROGRAMS	
Percentage Obligation Rate—2% per \$5,000 Annual Net Worth		Percentage Obligation Rate—1% per \$5,000 Annual Net Worth	
Dialysis—Only—Aid Code 71	Parenteral Hyperalimentation—Only—Aid Code 73	Dialysis Supplement—Aid Code 71 TPN Supplement Aid Code 73	
The applicant must meet <i>all</i> of the following: 1. Needs dialysis and related services 2. Ineligible for Medi-Cal under any other program due to excess resources 3. Meets Medi-Cal requirements of citizenship/immigration, residence, institutional status, linkage, and cooperation 4. \$250,000 maximum annual net worth 5. Ineligible for Medicare if under age 65		The applicant must meet <i>all</i> of the following: 1. Needs parenteral hyperalimentation and related services 2. Ineligible for Medi-Cal under any other program due to excess resources 3. \$250,000 maximum annual net worth 4. Be otherwise eligible for Medi-Cal except that linkage requirements are not necessary 5. Meets Medi-Cal requirements of citizenship/immigration, residence, institutional status, and cooperation	
The applicant must meet <i>all</i> of the following: 1. Needs dialysis or TPN and related services 2. Approved as Medi-Cal with a share of cost 3. Employed or self-employed 4. Earns an individual gross income in excess of the (regular) one-person maintenance need			

PART III. ANNUAL NET WORTH COMPUTATIONS

A. Real Property		C. Income	
1. Property use as a home: (a) Full market value \$ _____ (b) Exempted value \$ <u>-40,000</u> (c) Pro rata encumbrances \$ _____ (d) Excess market value (a-b+c) \$ _____ 2. Property not used as a home: (a) Full market value \$ _____ (b) Encumbrances \$ _____ (c) Net market value \$ _____ Total Real Property (1(d)+2(c)) \$ _____		5. Gross earned income for 12 months \$ _____ 6. Gross unearned income for 12 months \$ _____ 7. Total gross income (add lines 5 and 6) \$ _____ 8. Allowable adjustment deductions (per federal tax law) \$ _____ 9. Total adjusted gross income (line 7 - line 8) \$ _____	
B. Personal Property		D. Percentage Obligation Determination	
3. Liquid Assets—itemize: _____ \$ _____ _____ \$ _____ _____ \$ _____ Total _____ \$ _____ 4. Other—itemize: _____ \$ _____ _____ \$ _____ _____ \$ _____ Total Personal Property (3+4) \$ _____		10. Annual net worth (total of A+B+C rounded down to nearest multiple of \$5,000) \$ _____ 11. Percentage obligation factor (line 10 divided by \$5,000) \$ _____ 12. Percentage obligation rate _____ % 13. Percentage obligation—(line 11 multiplied by line 12) Enter in Block F, Part I above _____ %	

PART IV. COMMENTS AND SIGNATURE

Medicare effective: _____/_____/_____	Ineligible Medicare _____	Discontinued from Aid Code _____	Effective: _____/_____/_____
Aid Code discontinued because: _____			
Eligibility Worker's signature _____			Date _____

HC 176 D (4/87)

MEDI-CAL ELIGIBILITY PROCEDURES MANUAL

State of California—Health and Welfare Agency

Department of Health Services

MEDI-CAL NOTICE OF ACTION MEDI-CAL SPECIAL TREATMENT PROGRAMS

(COUNTY STAMP)

Notice date: _____

Case number: _____

Worker number: _____

Worker name: _____

Worker telephone number: _____

Approval/denial/discontinuance for: _____

(Name)

☐ You are eligible for the Medi-Cal: ☐ Dialysis ☐ TPN Special Treatment Program beginning _____.

Your obligation rate is _____ percent per \$5,000 on annual net worth up to \$250,000. Your annual net worth was determined to be \$ _____ for the twelve-month period from _____ through _____.

This means that the person or organization providing you with supplies and services will send a bill for that cost to your insurance company, or to any other agency that provides you with coverage for these supplies and services. You will pay or obligate _____ percent of the cost NOT paid by the insurance company or other agency. If you have no insurance or other coverage, you will pay or obligate _____ percent of the entire cost of the service. The costs not paid by your insurance or other coverage, or paid or obligated by you, will be paid by Medi-Cal.

☐ You must provide a copy of your notice of Medicare status from the Social Security Administration showing whether or not you are eligible for Medicare by _____. If you fail to provide this notification, or provide information on why you are unable to do so, your ☐ Dialysis ☐ TPN Special Treatment Program benefits will be discontinued.

☐ Your application of _____ has been denied for the Medi-Cal: ☐ Dialysis ☐ TPN Special Treatment Program because: _____

☐ Your eligibility has been discontinued for the Medi-Cal: ☐ Dialysis ☐ TPN Special Treatment Program effective _____ because: _____

The regulations which require this action are California Code of Regulations, Title 22, Section(s):

You must notify the county welfare department within ten days of any changes in income, property, or other circumstances. If you have other medical coverage, it must be used before Medi-Cal. Failure to tell the county welfare department about other health care coverage or failure to use other coverage available to you is a misdemeanor.

If you have any questions about this action or if there are additional facts relating to your circumstances which you have not reported to us, please write or telephone. We will answer your questions or make an appointment to see you in person.

PLEASE READ THE REVERSE SIDE OF THIS NOTICE

MC 220 F (2/87)

YOUR HEARING RIGHTS

- You only have 90 days to ask for a hearing. The 90 days started the day after we gave or mailed you this notice.
- You have a much shorter time to ask for a hearing if you want to keep your same benefits.

You must ask for a hearing before the action takes place.

- Your Cash Aid will stay the same until your hearing.
- Your Medi-Cal will stay the same until your hearing.
- Your Food Stamps will stay the same until the hearing or the end of your certification period, whichever is earlier.
- Your Transitional Child Care (TCC) will stay the same until the hearing or the end of your eligibility period, whichever is earlier. For all other child care programs, your benefits will NOT stay the same until your hearing.
- If the hearing decision says we are right, you will owe us for any extra cash aid or food stamps you got.

If you want your Cash Aid or Food Stamps cut while you wait for a hearing, check one or both boxes.

- ☐
- Cash Aid
- ☐
- Food Stamps

You can ask about your hearing rights or free legal aid at the state information number.

Call toll free: **1-800-952-5253**

If you are deaf and use TDD, call: 1-800-952-8349

You may get free legal help at your local legal aid office or welfare rights group.

Child and/or Medical Support: The District Attorney's office will help you collect support even if you are not on cash aid. There is no cost for this help. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you any current support money collected. They will keep past due money collected that is owed to the county.

Family Planning: Your welfare office will give you information when you ask for it.

Hearing File: If you ask for a hearing, the State Hearing Office will set up a file. You have the right to see this file. The State may give your file to the Welfare Department, the U.S. Department of Health and Human Services and the U.S. Department of Agriculture. (W. & I. Code Section 10950).

The best way to ask for a hearing is to fill out this page. Make a copy of the front and back for your records. Then, send or take this page to:

Your worker will get you a copy of this page if you ask. Another way to ask for a hearing is to call 1-800-952-5253. If you are deaf and use TDD, call: 1-800-952-8349.

I want a hearing because of an action by the Welfare Department
of _____ County about my

- ☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal ☐ Child Care
☐ Other (list)

Here's why: _____

- ☐ Check here and add a page if you need more space.
- ☐ I want the person named below to represent me at this hearing.
I give my permission for this person to see my records or come to the hearing for me.

NAME _____

ADDRESS _____

- ☐ I need a free interpreter.
My language or dialect is: _____

My name: _____

Address: _____

Phone: _____

My case number: _____

My signature: _____

Date: _____